Missouri Department of Insurance

Study to Assess the Impact of the Mental Health and Substance Abuse Insurance Act (HB 191)

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In fulfillment of the requirements of RSMo 376.836.

Executive Summary

Missouri law provides an array of mandated coverage and required offers of coverage that do not clearly state public policy objectives in health plans. The only coverage that is absolutely required is coverage for 30 days per year of alcoholism treatment, but HMOs are exempt from this requirement.

House Bill 191 of 1999 – the Missouri Mental Health and Chemical Dependency Insurance Act – was enacted with the intent of broadening coverage and providing greater benefit "parity" between physical and mental illnesses. Through 1999, Missouri required insurers (but not HMOs) to *offer* a minimum level of psychiatric and substance abuse benefits, although the policyholder/employer could decline that coverage except for the required alcohol treatment; after rejecting that offer, the policyholder could provide whatever benefits desired.

HB 191, however, required that prospective policyholders who rejected the mandatory offer and still wanted ANY coverage for mental health benefits had to purchase coverage for a minimum level of services.

HB 191 required the Missouri Department of Insurance to assess the statute's impact on four stakeholder groups: insurers, employers, medical providers and consumers of mental health and substance abuse services. Although MDI at best has limited authority to collect data from these groups, the study did ascertain:

- All but two of the 37 carriers surveyed reported that 100 percent of their insureds had mental health and substance abuse coverage.
- Missouri law presents obstacles to those persons most in need mental health services if they are seeking individual or small-group coverage. Insurers still can refuse to issue individual plans to insure mentally ill persons and, if such persons work in small companies, can price coverage to make it unattractive to employers. Larger groups, however, have few such concerns.
- Costs generally appear to have declined since 1998 as treatment has migrated from inpatient to less expensive outpatient settings.
- **No evidence exists that HB 191 caused insurers to reduce coverage** of mental health/substance abuse services in the state. Only 2 percent of the fully insured market dropped mental health or substance abuse coverage when HB 191 took effect.
- At least two-thirds of **insureds had their covered benefits increased** to meet the new minimums under HB 191, broadening the scope of services **without appreciable extra cost**.
- **HB 191 has had no discernible impact on the cost of health insurance in the state**. Overall, since 1998, the cost of mental health/substance abuse services has almost always been less than 4 percent of total claims expenses for all policies. Costs generally have been 2

percent or less of total claims for traditional indemnity insurers with slightly higher costs among HMOs that tend to provide broader coverage for all services. The cost share tends to decline with the size of employer groups.

I. Summary of the changes to Missouri law following passage of HB 191

House Bill 191, effective January 1, 2000, revised the following sections of Missouri's insurance laws regarding coverage of mental illness and substance abuse. The provisions of HB 191 relating to mental illness and chemical dependency are in the appendix to this report (p.30).

Throughout this report, a key distinction exists between *mandated* coverage and required *offers* of coverage for mental health and substance abuse treatment services. The buyer can reject an *offer* of coverage.

A. Section 376.779

1. Prior to HB 191

Subsection 1 *mandated* that health insurance policies, **but not HMO health plans**, cover alcoholism treatment in a hospital, residential or non-residential facility certified by the Department of Mental Health on the same basis as any other illness. Coverage may be limited to 30 days in any policy or benefit period.

Subsection 2 required insurers, **but not HMOs**, to *offer* benefits for chemical dependency and drug addiction. Benefits could be limited to 80 percent of the reasonable and customary charges for such services up to a maximum benefit of $2,000 during each policy or contract benefit period.

2. After HB 191

The provisions of subsection 2 were deleted, removing the requirement for insurers to *offer* coverage of chemical dependency.

B. Sections 376.810 to 376.814

1. Prior to HB 191

These sections describe the benefits for a recognized mental illness that insurers and HMOs must *offer* to applicants. The coverage *is not necessarily included* in every policy, based on the preference of the buyer, generally an employer. Insurers are treated differently than HMOs in these sections.

Section 376.810 defines "recognized mental illness" as any condition classified as "mental disorders" in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, excluding mental retardation.

Section 376.811 describes the benefits that must be *offered* to the prospective policyholder applicant; Subsection 1 describes an *offer* for coverage of

chemical dependency treatment and **does not apply to HMOs**; Subsection 2 describes an *offer* for coverage of mental health services and **applies to both insurers and HMOs**.

If the required offer is accepted by the policy holder, those benefits fully satisfy and substitute for the alcoholism coverage otherwise required by 376.779.

2. After HB 191

The provisions of section 376.811 were not materially changed by HB 191. This section allows carriers to limit mental illness benefits to services delivered by contracted community mental health centers or other contracted providers certified by the Department of Mental Health (DMH), or accredited by a nationally recognized organization or licensed by the state of Missouri.

A subsection was added to section 376.814, stating that coverage shall be governed by the Mental Health and Chemical Dependency Insurance Act (sections 376.825 to 376.835) if the *offer* required by 376.811 is rejected and the policy provides any benefits for mental illness.

C. Sections 376.825 to 376.835

HB 191 added six new statute sections, collectively cited as the Mental Health and Substance Abuse Treatment Act ("the Act"). These sections only apply if the policyholder rejects the *offer* of chemical dependency and mental illness benefits required by 376.811 and the policy provides any benefits for mental illness, as that term is defined in the Act (except for the coverage of alcoholism required by 376.779). When *offers* required by 376.811 are rejected, but the policy otherwise provides benefits for mental illness, the benefits for mental illness must at least equal the benefits set forth in the Act.

The definition of mental illness in the Act is more limited than Section 376.810. HB 191 used specific ICD-9 codes (International Classification of Diseases, version 9) to establish the minimum list of diseases that have to be covered, including schizophrenic disorders and paranoid states; major depression, bipolar disorder, and other affective psychoses; obsessive compulsive disorder, post-traumatic stress disorder and other major anxiety disorders; early childhood psychoses, and other disorders first diagnosed in childhood or adolescence; alcohol and drug abuse; anorexia nervosa, bulimia and other severe eating disorders; and senile organic psychotic conditions.

D. Limited applicability of HB 191

HB 191 does not affect many Missourians covered by employer health plans because it does not apply to self-funded employee health plans. Federal law pre-empts state insurance regulation of self-funded employee health plans, except those

of state, county and local governmental entities and churches. In addition, coverage under trust instruments issued in another state is not subject to HB 191.

II. Methodology – how impact was defined and assessed

A. Definition

MDI and DMH jointly defined "impact" as used in RSMo 376.836, given the needs of citizens for mental health and substance abuse treatment services. "Impact" was determined to mean:

1. cost of mental health and substance abuse treatment services for each year since 1998, to show the effect of HB 191 as of 2000;
2. cost of private insurance coverage for same services for each year;
3. availability of same services for each year; and
4. utilization of same services for each year.

B. Impact on **insurers and HMOs**

A direct survey of insurers and HMOs was developed. The survey instrument is included in this report as Exhibit 1, page 21. The survey was sent to the 10 largest insurers and HMOs selling coverage in the individual market, the 10 largest carriers in the small group market and the 10 largest carriers in the large group market. A health carrier's status in each market was determined based on the amount of premium collected in each market in 2002.

1. Insurance markets

MDI gathered information on each insurance market because a mandatory benefit or offer can have unique implications for each applicant, specifically for individuals and small employers. These three markets and the law's unique implications are:

a. The individual health insurance market – The individual market includes individual insurance policies or HMO health plans marketed directly to Missouri residents and families. The study did not include so-called "group association" policies that actually are sold to individuals because such policies are not subject to HB 191.

Except for persons guaranteed access to individual market coverage under the Health Insurance Portability and Accountability Act (HIPAA)[1], health insurers can use personal health information about individuals applying for a policy. An insurer can decide not to issue a policy based on the individual applicant's

[1] HIPAA is a federal law passed in 1996. Among other things, it was intended to eliminate "job lock". People who wanted to leave their job are guaranteed the right to buy an individual policy to replace health insurance provided by their current employer. In these situations, insurance companies and HMOs are not allowed to underwrite or exclude coverage for pre-existing conditions.

health information. If an applicant has a medical history that includes treatment of a mental illness, the insurer may reject the application.

Even though HIPAA-eligible persons are guaranteed access to an individual policy, the HIPAA laws do not prohibit insurers from charging rates that are unaffordable. As a result, coverage for mental illness is least available in the individual market for those who may have the greatest need.

b. The small group market – For this study, the small group market includes group health insurance and HMO coverage sold to Missouri employer groups with 2 to 50 full-time employees. (This definition comes from federal law, not state law. State law defines small groups as 3 to 25 full-time employees.) The employer is the policyholder. Typically, these policies also extend coverage to the employees' spouses and dependent children.

Under state law, small employers have the right to buy a policy from any insurer that offers coverage in that market, and coverage must be uniformly available to each employee. The small employer decides how much insurance premium it and employees are willing to pay. If the medical history of one or more employees or dependents includes treatment of a mental illness, the insurer may consider that health history when it sets the premium it will charge. Insurance coverage that includes benefits for mental illness may only be available if the employer is willing to pay higher premiums.

c. The large group market – This market includes group health insurance and HMO contracts issued in this state to insure union members and employees of employers with 51 or more full-time employees. These contracts typically extend coverage to the employees' or group members' spouses and dependent children.

Because larger groups help spread the risk of incurring medical claims, they are less affected than small groups by the medical history of any individual in the group. Large groups are much less likely than small groups to pay significantly higher premiums for mental illness benefits if a member has a history of mental health conditions.

2. Insurance carriers

MDI also distinguished the top 10 insurers from the top 10 HMOs in each market because of significant differences between the required mental health/substance abuse coverage offered by the two kinds of insurers.

MDI issued surveys to 37 carriers, which often had significant shares of all three markets. Therefore, MDI was able to limit the burden on the industry of gathering information. Table 1 (next page) shows the insurers that were surveyed, the markets they are known to operate in, their reported premium volume and their

percentage market share in each market. Table 2 provides the same information for HMOs. Shaded areas indicate the company was not a "top 10" company for the applicable market, but they reported information in this market anyway.

Table 1 – Surveyed Insurance Companies

Insurers:	Written Premium Volume			Market Share			
	Small Group	Large Group	Individual	Small Group	Large Group	Individual	Responded?
Aetna Life Ins. Co.		$ 9,244,088		0.80%	1.25%	0.05%	y
American Community Mutual Ins. Co.	$ 11,704,531			2.15%	0.39%	0.01%	y
American Family Mutual Ins. Co.			$ 24,029,049	0.00%	0.34%	8.72%	y
American Republic Ins. Co.			$ 5,628,864	0.00%	0.00%	2.04%	y
Blue Cross & Blue Shield of Kansas City	$ 67,704,703	$ 94,082,662	$ 58,748,231	12.46%	12.67%	21.33%	y
Connecticut General Life Ins. Co.		$ 49,593,609		0.00%	6.68%	0.00%	n
Continental General Ins. Co.			$ 3,263,492	0.00%	0.00%	1.18%	n
Coventry Health and Life Ins. Co.		$ 15,273,028		0.00%	2.06%	0.00%	n
Cox Health Systems Ins. Co.	$ 11,094,864	$ 22,525,935	$ 2,560,598	2.04%	3.03%	0.92%	y
Federated Mutual Ins. Co.	$ 18,247,158			3.36%	0.26%	0.00%	n
Fortis Benefits Ins. Co.	$ 16,849,285			2.92%	0.37%	0.00%	y
Fortis Ins. Co.			$ 5,192,495	0.61%	0.01%	1.89%	y
Healthy Alliance Life Ins. Co.	$ 301,118,536	$ 333,457,323	$ 149,423,675	55.42%	44.92%	54.25%	y
Humana Ins. Co.	$ 14,629,593			2.69%	0.49%	0.01%	y
John Alden Life Ins. Co.	$ 11,706,433			2.15%	0.00%	0.09%	y
Missouri Valley Life and Health Ins. Co.			$ 1,848,403	0.09%	0.00%	0.67%	n
Principal Life Ins. Co.	$ 23,200,561			4.27%	1.01%	0.00%	y
Reserve National Ins. Co.			$ 4,116,258	0.00%	0.00%	1.49%	y
State Farm Mutual Automobile Ins. Co.		$ 13,318,788	$ 6,324,284	0.00%	1.79%	2.30%	y
Trustmark Ins. Co.		$ 13,521,314		1.37%	1.82%	0.07%	y
Unicare Life & Health Ins. Co.		$ 12,585,597		0.00%	1.76%	0.03%	n
United Healthcare Ins. Co.		$ 114,463,967		1.79%	15.42%	0.00%	y
United Wisconsin Life Ins. Co.	$ 14,722,565			2.71%	0.18%	0.01%	y
Percent of Market Surveyed				94.83%	94.45%	94.89%	
Percent of Market Responded				91.47%	83.95%	93.04%	

Table 2 – Surveyed HMOs

HMOs:	Written Premium Volume			Market Share			
	Small Group	Large Group	Individual	Small Group	Large Group	Individual	Responded?
Aetna Health, Inc.	$ 17,150,011	$ 38,902,172	$ -	3.15%	2.37%	0.00%	y
Blue Cross & Blue Shield of Kansas City	$ 14,245,000	$ 43,263,000	$ 8,386,073	2.61%	2.64%	5.89%	y
CIGNA Healthcare of KS/MO	$ 2,219,108	$ 4,274,221	$ 11,712	0.41%	0.26%	0.01%	n
Community Health Plan	$ 5,551,718	$ 54,256,998	$ -	1.02%	3.31%	0.00%	y
Coventry Health Care of Kansas, Inc.	$ 39,009,539	$ 161,919,138	$ -	7.16%	9.88%	0.00%	y
Cox Health Systems HMO, Inc.	$ 7,928,206	$ 36,117,379	$ -	1.45%	2.20%	0.00%	n
Good Health HMO, Inc. dba Blue Care, Inc.	$ 6,904,000	$ 24,294,000	$ 50,456,069	1.27%	1.48%	35.45%	y
Group Health Plan, Inc.	$ 59,056,091	$ 233,906,349	$ 791,018	10.83%	14.27%	0.56%	y
HealthLink HMO, Inc.	$ 11,324	$ 2,285,420	$ 14,482,617	0.00%	0.14%	10.17%	n
HMO Missouri, Inc. dba Blue Choice	$ 40,739,562	$ 158,618,655	$ 18,661,187	7.47%	9.68%	13.11%	y
Humana Health Plan, Inc.	$ 1,061,006	$ 67,177,036	$ 15,302,565	0.19%	4.10%	10.75%	y
Mercy Health Plan of Missouri, Inc.	$ 49,875,635	$ 233,937,618	$ -	9.15%	14.27%	0.00%	y
Prudential Health Care Plan, Inc.	$ 126,476	$ 873,521	$ 56,750	0.02%	0.05%	0.04%	n
United Healthcare of the Midwest, Inc.	$ 295,789,098	$ 530,899,269	$ 34,200,346	54.26%	32.39%	24.03%	y
Percent of Market Surveyed				99.00%	97.06%	100.00%	
Percent of Market Responded				97.12%	94.41%	89.78%	

In addition to survey information, HMOs in Missouri have reported costs associated with mental health and substance abuse services for many years. In several instances, HMOs could not provide cost information as requested on the survey. The regular HMO cost reporting is less detailed and less specific than the information requested on the survey. However, MDI reviewed this alternative source of cost information.

HMOs in Missouri report regularly on the utilization of mental health and substance abuse services by their enrollees. These reports go back to 1995. The reporting instruments used for mental health and substance abuse utilization appear as Exhibit 3, page 25. HMOs in Missouri also regularly report their participating mental health and substance abuse providers, through annual access plans. Annual HMO access plans have been reported since 1998 and include information on:

- Outpatient-adult mental health treatment providers
- Outpatient-child/adolescent mental health treatment providers
- Outpatient-geriatric mental health treatment providers
- Inpatient/intensive treatment-adult mental health treatment providers
- Inpatient/intensive treatment-child/adolescent mental health treatment providers
- Inpatient/intensive treatment-geriatric mental health treatment providers
- Inpatient/intensive treatment-alcohol/chemical dependency treatment providers

This regularly reported information was used as one means to assess utilization and availability of mental health and substance abuse treatment services.

C. Impact on **business interests**

As stated earlier, neither MDI nor DMH has the capacity or authority to collect information from **private business interests**, such as employers. As a substitute, MDI worked with the Missouri Consolidated Health Care Plan ("MCHCP"), which insures thousands of state and local government employees through private plans, to evaluate the impact. Section III contains partial information from MCHCP. MDI evaluated copies of the MCHCP member handbooks and contracts for each year since 1998 to determine the nature of coverage for mental health and substance abuse services. In particular, MDI looked at any changes that may have occurred after 1999.

D. Impact on **providers**

MDI worked with the DMH and the Missouri Hospital Association to gather information from **providers of mental health and substance abuse treatment services**. The survey instrument is included in this report as Exhibit 2, page 23. The survey was sent to 69 psychiatric hospitals and hospital units, 22 community mental health centers and an unknown number of private practitioners. Neither MDI nor DMH has authority to compel providers to provide information. Only 16 total

providers responded: six community mental health centers; seven psychiatric hospitals or hospital units; and three responses from providers who didn't identify themselves.

E. Assessing impact on individual **consumers** of mental health and substance abuse treatment services

As stated above, neither MDI nor DMH has the capacity or authority to collect information from **individual consumers for mental health and substance abuse treatment services**. Due to considerable federal requirements regarding the protection of non-public personal health information, no attempt was made to identify or survey such individuals.

F. Literature Review

To compensate for deficiencies in MDI's ability to assess the impact of HB 191 on private businesses and consumers of mental health and substance abuse treatment services, MDI reviewed published research. See Section IV, beginning on page 15.

III. Findings

A. Impact on **insurers and HMOs**

Since 1998, all but two carriers reported that 100 percent of their enrollees have had some kind of mental health and substance abuse coverage. This has been true in all three markets. However, before HB 191, most carriers reported that the mental health and substance abuse coverage was less generous than the minimum coverage required under the new bill. Between 1999 and 2000, policy holders had to choose to either enhance benefits in order to meet the new minimum requirements, or drop coverage completely. Most carriers reported that policyholders chose to upgrade their coverage. Only about 2 percent of insured persons lost or dropped their mental health and substance abuse coverage as a result of HB 191. **At least two-thirds of the market enhanced coverage to meet the new minimum standards.**

1. Cost of services

MDI asked carriers to identify whether claim costs were associated with coverage that complies with RSMo 376.811 or with coverage that complies with HB 191. Some carriers have both. When MDI asked carriers to distinguish between claim costs associated with 376.811 and those associated with HB 191 version of coverage, not all carriers could do so.

The responses that MDI received indicate slightly different experience for HMOs than for insurance companies. However, **the portion of claim costs attributable to claims for mental health and substance abuse services has almost always been less than 4 percent of total claim costs** since 1998 in all three markets,

for whatever version of mandated mental health and substance abuse coverage carriers provide. Insurance companies reported that mental health and substance abuse claim costs have almost never exceeded 2 percent of total claims since 1998.

Table 3 shows the average reported portion of total claim costs that are attributable to claims for mental health or substance abuse services. HMOs are shown separately from insurance companies.

Since 1998, carriers have reported relatively moderate increases in the cost of mental health and substance abuse services, and costs seem to have actually dropped from 2001 to 2002. **No indication exists that HB 191 appreciably increased the cost of mental health and substance abuse services.**

The cost of private insurance coverage overall has been on a steady upward trend since the mid-1990s, primarily attributed to provider reimbursements and utilization rates. Although the cost of private insurance generally rose the year HB 191 went into effect, **the proportion of benefits paid did not increase for mental health and substance abuse treatment services, even though a substantial majority of fully insured people enhanced their coverage to meet the new minimum requirements. HB 191 consequently was not a significant factor in the cost of private insurance coverage.**

Table 3 – Percent of total claims attributable to mental health/substance abuse treatment

	376.811 coverage					Mental Health and Substance Abuse Insurance Act coverage				
Insurers:	**1998**	**1999**	**2000**	**2001**	**2002**	**1998**	**1999**	**2000**	**2001**	**2002**
Small Group	1.25%	1.39%	2.19%	1.75%	1.40%	1.71%	1.86%	1.90%	1.65%	1.58%
Large Group	2.23%	1.28%	1.69%	1.69%	1.77%	0.99%	1.37%	1.69%	1.67%	1.35%
Individual	0.89%	1.50%	1.40%	1.45%	1.04%	1.23%	1.91%	1.47%	0.86%	0.91%
HMOs:	**1998**	**1999**	**2000**	**2001**	**2002**	**1998**	**1999**	**2000**	**2001**	**2002**
Small Group	1.70%	2.08%	2.16%	2.19%	2.09%	2.50%	2.90%	2.10%	1.98%	1.98%
Large Group	1.70%	1.98%	2.06%	2.15%	2.08%	2.50%	2.66%	2.10%	1.98%	1.98%
Individual	*	3.25%	3.57%	3.23%	3.47%	*	4.70%	N/A	N/A	N/A

*No information was reported
"N/A" reflects the fact that no HMO in the individual market reported claim costs attributable to the new minimum HB 191 coverage.

2. Cost of private insurance coverage

HB 191 sets a minimum standard, or a "floor," for mental health and substance abuse treatment coverage that carriers must have in their policies, with one important exception: Carriers do not have to cover mental health services at all. Policyholders are free to forgo any coverage whatsoever for mental health services. Policyholders are *not* free to have benefits below the minimums stated in HB 191.

The carriers that MDI surveyed were asked to identify whether their policies had any kind of standard mental health and substance abuse coverage and whether

changes were required by HB 191. All but two carriers reported that 100 percent of their enrollees have had some kind of standard coverage since 1998. **Only one carrier removed the standard coverage as a direct result of HB 191 because the standard coverage would not have met the new minimum requirements.**

For the carriers that MDI surveyed, at least 75 percent of the fully insured market had mental health or substance abuse coverage that didn't meet the new minimum requirements, prior to the effective date of HB 191. However, **only about 2 percent of the fully insured market dropped mental health or substance abuse coverage the year HB 191 went into effect**. **At least two-thirds of the market enhanced coverage** to meet the new minimum standards.

3. Utilization of services

   HMO data filed with MDI indicates that utilization of covered mental health and substance abuse services is very low. Similar data is not available for insurers. The rates of utilization for HMOs are so low that trending available data is meaningless and could lead to wildly erroneous conclusions. To the extent that claims experience indicates the rate of utilization, **MDI cannot identify any effect attributable to HB 191.**

4. Availability of services

   HMOs are required to file data that identifies their mental health and substance abuse providers every year. No similar data is collected for insurance companies. HMOs are required to meet access-to-care standards, but are entitled to exceptions if insufficient providers are available. To determine when exceptions should apply, MDI annually gathers information on availability of all mental health and substance abuse treatment providers licensed in Missouri and the non-Missouri portions of the Kansas City and St. Louis metropolitan areas. MDI calculates a rate indicating how well each county in Missouri is supported by mental health and substance abuse treatment providers. This information goes back to 1998 and shows a general decline in the number of licensed mental health and substance abuse treatment providers. However, the decline in these types of providers is not significantly different from declines in many types of medical providers. **No clear indication exists that HB 191 had any particular impact on availability of services.**

B. Impact on **private business interests**

MDI and DMH have no practical ability to study the effect of HB 191 on **private businesses**, such as employers. MDI looked to the Missouri Consolidated Health Care Plan ("MCHCP") as a possible proxy.

MCHCP is not necessarily a good proxy for evaluating the impact of HB 191 on large employers because MCHCP's covered benefits complied with 376.811 both before and after the effective date of HB 191. MCHCP's experience illustrates that providing comprehensive mental illness benefits doesn't significantly add to health plan costs for a large employer, which is consistent with studies of the federal parity law. (Additional information about such studies is presented in Section IV, page 15.)

1. MCHCP cost of services

   Other than descriptions of the covered services, MCHCP was able to provide minimal data regarding cost and utilization of covered mental health and substance abuse treatment services. Data from MCHCP is limited because not all MCHCP contracting health plans reported mental health and substance abuse treatment claim costs separately. As reported by the health plans, MCHCP's per-member-per-month mental health and substance abuse treatment claims costs from 1998 to the present were:

Year	PMPM
1998	$0.92
1999	$0.74
2000	$1.04
2001	$1.79
2002	$1.92
2003	$1.57

   MCHCP could not provide the portion of total claims represented by mental health and substance abuse treatment claims in the format used for the health carrier survey. However, MCHCP's data shows trends in mental health and substance abuse treatment claim costs since 1998 similar to trends in a study of the federal parity law. See Section IV.

2. Cost of coverage

   MCHCP's costs for coverage are rising, but as stated earlier, no single factor or event can be isolated as having any particular effect on the cost of coverage. MCHCP's mental health and substance abuse coverage has been consistent with the provisions of RSMo 376.811 since 1998. No change was made after the effective date of HB 191. Therefore, HB 191 had no impact on MCHCP's total cost of coverage.

3. Utilization of services

   MCHCP does not require its private insurers to provide utilization data. Utilization data that HMOs file with MDI, including fully insured MCHCP data, indicates that utilization of mental health and substance abuse services is

extremely low, but also extremely variable. It's not possible to state definitively what kind of change occurred between 1999 and 2000.

4. Availability of services

   MCHCP had no information to report on the availability of services. However, MCHCP contracts require HMOs to use the same network for MCHCP enrollees that other commercial enrollees use. Commercial HMO networks tend to exhibit difficulty meeting the access-to-care standards for mental health and chemical dependency treatment providers. In some cases, they cite to an insufficient number of providers with which to contract. Problems with access to mental health and chemical dependency treatment providers have been stable over time.

C. Impact on **providers**

The extremely low number of responses MDI received to the provider survey makes it impossible to draw definitive conclusions. Of the 16 providers that responded to the survey, only 15 delivered mental health and chemical dependency treatment services after HB 191 took effect. One of those did not serve the privately insured population.

1. Cost of services

   Of the providers that responded to MDI's survey, one provider indicated a 5 percent drop in the amount charged for services. One provider indicated an increase, but did not report the magnitude of the increase. One provider had no information to report. All other respondents indicated no change in amounts charged as a result of HB 191.

2. Cost of private insurance coverage

   Regarding the volume of privately insured patients seen since HB 191 went into effect, the six community mental health centers uniformly reported no change, but other types of providers seem to have been more affected. Community mental health centers are almost exclusively treating DMH clients and may be insulated somewhat from private insurance coverage mandates. One purpose of HB 191 was to increase private insurance payments to community mental health centers so they were no longer solely dependent on DMH funding. Provider responses indicate that has not happened.

   Two hospitals reported increases in the volume of patients since HB 191 went into effect. One of these reported a 15 percent increase and the other reported a 20 percent increase. One hospital reported a 15 percent decrease in the volume of privately insured patients. Of the seven hospitals that responded, one ceased offering mental health and substance abuse treatment services as of 2000.

Three providers of an unknown type responded. Two of these reported decreases in the volume of privately insured patients since HB 191 went into effect. One reported a 7 percent decrease, and the other reported a 20 percent decrease. The third provider reported no change.

3. Utilization of services

   Section 2 can also be viewed as reflecting the utilization of services by privately insured patients.

4. Availability of services

   MDI asked providers if they provide specifically the types of services defined in HB 191, the percentage of their business reimbursed by private insurance or HMO coverage, and whether or not reimbursement from private insurance companies and HMOs had changed since HB 191 went into effect. Changes in the percent of business that is reimbursed by private insurance or HMO coverage would indicate the availability of services for privately insured people. Questions regarding the services each provider offers were asked exactly as the services are listed in RSMo 376.826, subdivision 4.

   Table 4 reflects services listed in HB 191 and how many providers offered them.

Table 4 – Provider responses

Type of service, as defined in the Act	Total Responding Providers Offering Each Type of Service					
	2003	2002	2001	2000	1999	1998
schizophrenic disorders and paranoid states	14	14	14	15	15	14
major depression, bipolar disorder and other affective psychoses	15	15	15	16	16	15
obsessive compulsive disorder, post-traumatic stress disorder and other major anxiety disorders	15	15	15	16	16	15
early childhood psychoses and other disorders first diagnosed in childhood or adolescence	12	12	12	13	13	13
alcohol and drug abuse	9	9	9	10	10	10
anorexia nervosa, bulimia and other severe eating disorders	8	8	8	9	9	9
senile organic psychotic conditions	9	9	9	10	10	10
Average portion of services listed above for which private insurance or HMO reimbursement is received by **Community Mental Health Centers**	4.42%	4.25%	4.25%	4.25%	4.25%	4.26%
Average portion of services listed above for which private insurance or HMO reimbursement is received by **Hospitals**	41.38%	41.38%	41.38%	41.38%	43.50%	43.50%
any other recognized mental illness (except mental retardation)?	9	9	9	10	10	10
Average portion of other services for which private insurance or HMO reimbursement is received by **Community Mental Health Centers**	2.63%	2.63%	2.63%	2.63%	2.63%	2.63%
Average portion of other services for which private insurance or HMO reimbursement is received by **Hospitals**	80.00%	80.00%	75.00%	75.00%	75.00%	75.00%

The services in HB 191 are all offered by at least eight of the 16 responding providers. In addition, Table 4 shows the average portion of business at community mental health centers and hospitals that is reimbursed by private insurance companies or HMOs. Three responding providers did not report the percentage of their business that is reimbursed by private insurance or HMO coverage.

MDI asked providers if they experience limitations imposed by insurance companies or HMOs and, if so, the types of limitations they experience. Providers were also asked if the scope of services reimbursed by private insurance or HMOs had changed after the effective date of HB 191.

a. All but two of the responding providers reported they were restricted in the services they could provide to fully insured patients because of benefit limitations imposed by insurers and HMOs. The limitations included benefit caps, limits on types of reimbursable services, application of large copayments or deductibles and application of prior authorization requirements. Only one provider reported that co-payments and deductibles applied to mental health and substance abuse services were larger than copayments applied to physical health services.

b. Four providers reported that the scope of reimbursable services had narrowed. The remaining 12 providers reported they experienced no particular change in the scope of reimbursable services.

D. Impact on **consumers** of mental health and substance abuse treatment services

MDI and DMH have no practical ability to assess the impact of HB 191 on private consumers of mental health and substance abuse treatment services. No attempt was made to identify such consumers. However, some information provided by insurance companies and HMOs indicates HB 191 did not have a negative effect on private insurance coverage for mental health and substance abuse treatment services. About three fourths of persons with fully insured mental health and substance abuse coverage had benefits that did not meet the new minimum standards for coverage enacted with passage of HB 191. The overwhelming majority of these insureds raised the level of their benefits to meet the new minimum standards, indicating **the cost of richer coverage did not impact health insurance coverage**.

IV. Literature Review

A. Study on the effect of parity laws on employers: Department of Health and Human Services, Centers for Mental Health Services, "Effects of the Mental Health Parity Act of 1996"

The federal Mental Health Parity Act of 1996 has been exhaustively studied. A report on the impact the federal law had on health plans and employers indicates

trends and experiences very similar to MDI's responses from Missouri health plans. This report is brief and provides useful tables. Therefore it is reproduced in its entirety here:

"This report provides information on the effects of the federal Mental Health Parity Act of 1996 (MHPA), which became effective on January 1, 1998. Under the Act, group health plans providing both medical/surgical benefits and mental health benefits may not impose a lifetime or annual dollar limit on mental health benefits that is less than that applied to its medical/surgical benefits. MHPA includes a sunset provision which becomes effective on September 30, 2001.

Group health plans, and health insurance coverage offered in connection with group health plans, are not required by MHPA to provide mental health benefits. In addition, the law does not affect other terms and conditions (e.g., cost sharing and limits on visits or days) relating to the amount, duration, or scope of mental health benefits. Finally, MHPA protections do not extend to benefits for substance abuse or chemical dependency.

Employers with 50 or fewer employees are exempt from the Act. Also, a plan may be exempted from the Act if implementation results in an increase in plan costs of at least 1 percent.

Method

Data are from the Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans, and were analyzed under a contract supported by the Offices of Managed Care in CMHS and CSAT, SAMHSA. The Mercer/Foster Higgins survey collects information on a wide range of health care issues concerning employer health plans, including costs, strategic planning, and scope and limitations of health coverage. In 1998, this survey was administered from July through September, and included questions on employers' responses to MHPA.

The survey instrument was mailed to a stratified random sample of all U.S. employers including state and local governments who sponsor insurance with ten or more employees and who sponsor insurance. For private firms in the survey, a random sample was drawn from the Dun and Bradstreet database, stratified in eight size categories. All state governments were included; a random sample of county and local governments was drawn from the Census of Governments.

The 1998 database included 3725 respondents, representing a 55 percent response rate. Each respondent was requested to be the person "who knows the most about the health care benefits program." For the analysis of questions related to MHPA, respondents not subject to the Act (e.g., those with no MH coverage or with fewer than 50 employees) were eliminated. This left a total of 1946 respondents. Responses from these were weighted to reflect the actual national distribution of employers by firm size.

Results

Many employers have benefit plans that do not have annual or lifetime limits for MH benefits, or took early actions to comply with MHPA. Table 1 shows that nearly half of those subject to the Act were in compliance prior to its

effective date. Slightly more than a quarter either retained separate MH limits, but raised them, or included MH expenses with others in determining annual or lifetime dollar limits. About a fifth of respondents indicated that they had not yet taken action in response to the Act. This response was more common among employers with fewer than 500 employees. Larger employers were more likely to include MH expenses in determining overall limits or to take other actions in responding to MHPA.

Most employer-sponsored health plans treat mental health and substance abuse services similarly. However, MHPA only required plans to equalize spending limits for mental health services. The survey therefore asked employers that had taken some action to comply with MHPA whether they also took the same action for their substance abuse benefits. More than two-thirds (68 percent) said that they did. This response was more common among smaller employers.

Finally, there has been concern that MHPA and similar parity mandates may result in employers dropping MH coverage altogether, or increasing other limits in compensation. Table 2 provides information on such actions, for employers that made MHPA-related changes to their benefit. Of these, the large majority (86 percent) indicated that they made no compensatory changes to their benefit, usually because expected cost increases were judged to be minimal or nonexistent. The remainder did make some type of compensatory changes in benefits or administration, most commonly by increasing limits on inpatient days and/or outpatient visits. These types of actions were more common among larger employers.

Summary

These results indicate that the effects of MHPA have been largely positive. Only about half of the health plans subject to the Act had to make changes in their MH benefits. Of these, the large majority did not judge that the mandate required compensating changes in other benefit provisions. Further, MHPA had an unintended beneficial effect of also improving coverage for substance abuse benefits in many plans. Nevertheless, some employers did make changes that would tend to nullify any beneficial effects of the legislation, and a very small number actually dropped MH coverage.

For further information, contact:
Jeffrey A. Buck, Ph.D.
Director, Office of Managed Care
Center for Mental Health Services, SAMHSA
(301)443-0588

Table 1
Responses (in percent) to the Mental Health Parity Act,
by Size of Employer

Response	Number of Employees		
	Under 500	More than 500	Total

In compliance before 1998	47%	40%	46%
Dropped mental health coverage	1	1	1
Retained separate mental health limits, but raised to equal medical/surgical	11	14	11
Mental health costs are now included with medical/surgical in determining limits	16	23	17
Other	5	16	6
No action taken yet	22	6	21

- Unweighted N = 1946
- Note: Percentages do not add to 100 due to rounding.
- Source: 1998 Mercer/Foster Higgins National Survey of Employer-sponsored Health Plans

Table 2
Compensatory Changes Made to Plans,
by Size of Employer

Changes	Number of Employees		
	Under 500	**More than 500**	**Total**
No changes made, no increased costs expected	74%	43%	68%
No changes made, possible increased costs affordable	4	7	5
No changes made, not enough information yet	12	15	13
Day/visit limits were implemented or changed	10	34	14
Employee cost-sharing was increased	1	2	1
Changes were made in administration or utilization management	1	2	1
Other changes were made	1	3	1

- Unweighted N = 882
- Note: More than one response could be chosen, therefore, percentages do not add to 100.
- Source: 1998 Mercer/Foster Higgins National Survey of Employer-sponsored Health Plans"

B. Study on the effect of parity laws on consumers: National Institute of Mental Health, Final Report to Congress by the National Advisory Mental Health Council on the Effect of Insurance Parity for Mental Health: Cost, Access and Quality"

The most recent report from the National Institute of Mental Health provides some insight as to why claim costs for mental health/substance abuse treatment services as a percentage of total claim costs have decreased. "The experience of the [Federal Employees Health Benefit Program] program, along with other evidence, suggests that mental health and substance abuse costs have declined substantially during the 1990s, **mainly due to sharply reduced inpatient utilization** even in [fee-for-service/preferred provider organization] plans."

C. Study on the effect of parity laws on consumers: State of Minnesota, Office of the Legislative Auditor, "Insurance for Behavioral Health Care"

This report is limited to examination of the parity law enacted by the state of Minnesota in 1995. Minnesota's parity law is acknowledged as among the strongest in the United States. This study is consistent with MDI's findings that mental health and substance abuse claim costs as a portion of total health care claim costs have actually decreased. An interesting finding for Minnesota was that the parity law had very little impact on the utilization of mental health and substance abuse treatment services, which researchers attributed to the high prevalence and utilization controls of managed care in Minnesota.

VI. Exhibits

EXHIBIT 1

Missouri Department of Insurance
Impact of the Mental Health and Chemical Dependency Insurance Act

Definitions:
Enrollee means any person eligible for coverage under a health benefit plan, including eligible dependents.
Mental Health and Chemical Dependency Insurance Act of 1999 ("**MHCDI Act**") refers to the minimum coverage of mental health and substance abuse services required under RSMo 376.825 through 376.840, if such services are covered at all.
Small group market means coverage sold to Missouri employer groups with 2-50 eligible employees in the group.
Large group market means coverage sold to Missouri employer groups with 51 or more eligible employees in the group.

Less generous means, for example, cost sharing was greater for mental health or substance abuse services than for physical health care services, or maximum yearly/lifetime benefits were lower for mental health or substance abuse services than for physical health services, or substance abuse services were excluded from coverage completely. Other examples could apply.

All information provided should reflect **FULLY INSURED** business only.

Some of the questions below ask for percentages (%). If it's easier to respond with dollar or numeric amounts, please feel free to do so. Please indicate if your responses are percents or not.

Section 1 - Please identify yourself

Company Name:	
Name of Person Responding to Survey:	
Phone # of Person Responding to Survey:	
email for Person Responding to Survey:	

Section 2 - Yes or No questions (If your company doesn't sell individual coverage, indicate "NA".)	Individual Policies		Small Group Market		Large Group Market	
	YES	NO	YES	NO	YES	NO
1) Prior to the effective date of the MHCDI Act, did your policies always include some level of mental health or substance abuse coverage as part of the standard contract benefit?						
2) If "yes", do your policies continue to include some level of mental health or substance abuse coverage as part of the standard contract benefit?						
3) If "no", is it because the standard level of mental health or substance abuse benefits formerly included in your policies would not have met the minimum requirements of the MHCDI Act?						
4) **For HMOs only**, does the standard benefit plan design include or offer benefits or coverage for chemical dependency?						

Missouri Department of Insurance

EXHIBIT 1

Impact of the Mental Health and Chemical Dependency Insurance Act

Section 3 - Before and After questions
(If your company doesn't sell individual coverage, indicate "NA".)

		Individual Policies		Small Group Market		Large Group Market	
		1999	2000	1999	2000	1999	2000*
1)	What percentage (%) of enrollees had mental health/substance abuse coverage that could be characterized as "less generous" than the coverage required by the Mental Health and Chemical Dependency Insurance Act?						
2)	Of the enrollees that had "less generous" coverage than that required by Missouri's MHCDI Act, what percentage (%) of enrollees increased their level of benefits to meet the minimum standards of the MHCDI Act?						
3)	Of the enrollees that had "less generous" coverage than that required by Missouri's MHCDI Act, what percentage (%) of enrollees dropped mental health/substance abuse benefits completely?						

* Missouri's MHCDI Act became effective on 1-1-00 for policies issued, renewed or delivered in Missouri, except for multi-year contracts. For multiyear contracts, report in the 2000 column, regardless of the actual date the contract came up for renewal.

Section 4 - Trend questions - costs and coverage
(If your company doesn't sell individual coverage, indicate "NA".)

		1998	1999	2000	2001	2002
1) What percentage (%) of all enrollees had some form of mental health or substance abuse coverage?	individual					
	small group					
	large group					
2) What percentage (%) of enrollees had coverage specifically for chemical dependency or substance abuse (other than alcoholism)?	individual					
	small group					
	large group					
3) What percentage (%) of enrollees had coverage specifically for alcoholism?	individual					
	small group					
	large group					
4) For business where coverage complies with the requirements of RSMo 376.811, what percentage (%) of all claim costs incurred were claims for mental health/substance abuse services?	individual					
	small group					
	large group					
5) For all other business where mental health and substance abuse services are covered, what percentage (%) of all claim costs incurred were claims for mental health/substance abuse services?	individual					
	small group					
	large group					

Please send your completed survey by November 15, 2003 to:

Mr. James Casey. Life & Health Supervisor
Missouri Department of Insurance
PO Box 690
Jefferson City, MO 65101-0690

Contact Information

If you have any questions or comments, please contact:

Mr. James Casey (573)751-1953 Jim.Casey@insurance.mo.gov

or

Molly White (573)526-4106 Molly.White@insurance.mo.gov

Missouri Department of Insurance EXHIBIT 2

Impact of Mental Health and Chemical Dependency Insurance Act

Definitions:

Mental Health and Chemical Dependency Insurance Act of 1999 ("**MHCDI Act**") refers to the minimum coverage of mental health and substance abuse services required under RSMo 376.825 through 376.840, if such services are covered at all.

ICD-9-CM means the International Classification of Diseases.

Private health insurance coverage means health insurance coverage that is not a government program and not workers compensation.

All answers should **EXCLUDE** information related to any **WORKERS COMPENSATION** insurance that may have paid for some of your services.

Section 1 - Describe the services you provide (Provide past information to the best of your ability to recall.)		2003 (currently)		2002		2001		2000		1999		1998	
Do you provide services to treat:		YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO
1)	schizophrenic disorders and paranoid states (295 and 297, except 297.3, in the ICD-9-CM)?												
2)	major depression, bipolar disorder and other affective psychoses (296 in the ICD-9-CM)?												
3)	obsessive compulsive disorder, post-traumatic stress disorder and other major anxiety disorders (300.0, 300.21, 300.22, 300.23, 300.3 and 309.81 in the ICD-9-												
4)	early childhood psychoses and other disorders first diagnosed in childhood or adolescence (299.8, 312.8, 313.81 and 314 in the ICD-9-CM)?												
5)	alcohol and drug abuse (291, 292, 303, 304 and 305, except 305.1 in the ICD-9-CM)?												
6)	anorexia nervos, bulimia and other sever eating disorders (307.1, 307.51, 307.52 and 307.53 in the ICD-9-CM)?												
7)	senile organic psychotic conditions (290 in the ICD-9-CM)?												
8)	Of the services you provide, as reflected **above** in #s 1-7, what percentage of these services were reimbursed by insurance companies or HMOs each year?												
9)	any other recognized mental illness (any condition classified as a "mental disorder" in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, except mental retardation)?												
10)	Of the services you provide, as reflected in **#9 only**, what percentage of these services were reimbursed by insurance companies or HMOs each year?												

Missouri Department of Insurance EXHIBIT 2

Impact of the Mental Health and Chemical Dependency Insurance Act

Section 2 - Questions about insurance coverage for services you provide

1)	Do you currently serve patients with private health insurance coverage that pays for the services you provide?	YES	NO
2)	Do you currently experience limitations on the services patients can pay for due to benefit limitations imposed by their private health insurance coverage?	YES	NO
3)	If yes, please describe the types of limitations imposed by insurance companies and HMOs:		

Section 3 - Cause and Effect questions

1)	Since the MHCDI Act went into effect in 2000, have you experienced a greater or lessor volume of of patients with private health insurance coverage for your services?	Greater	Lesser	No Change
2)	If a change was experienced, estimate the percentage increase or decrease:	Estimated percentage of change:		
3)	Did your charges for mental health or substance abuse services change **as a result of** the MHCDI Act?	Higher charges	Lower charges	No Change
4)	If a change was experienced, estimate the percentage increase or decrease:	Estimated percentage of change:		
5)	Did you gain or lose patients with private health insurance coverage for your services after the MHCDI Act went into effect in 2000?	Gained patients	Lost patients	No Change
6)	If a change was experienced, estimate the percentage increase or decrease:	Estimated percentage of change:		
7)	Has the amount you are reimbursed by insurance companies or HMOs increased or decreased since 1-1-00?	Increased	Decreased	No Change
8)	If a change was experienced, estimate the percentage increase or decrease:	Estimated percentage of change:		
9)	Did the scope of coverage (or reimbursable services) expand or get narrower after 1-1-00 (for example, exclusion or non-reimbursement of treatment for sexual disfunction)?	Expanded	Narrowed	No Change
10)	If a change was experienced, estimate the percentage increase or decrease:	Estimated percentage of change:		

Please send your completed survey by November 26, 2003 to:

Mr. James Casey. Life & Health Supervisor
Missouri Department of Insurance
PO Box 690
Jefferson City, MO 65101-0690

Contact Information

If you have any questions or comments, please contact:

Mr. James Casey	(573)751-1953	Jim.Casey@insurance.mo.gov
Molly White	(573)526-4106	Molly.White@insurance.mo.gov

Table 2 - (Specify Category of Membership)
(Company Name)
For the reporting period ending: (insert appropriate date)

Hospital Utilization:

A) General Hospital/Acute Care Facility	**Days**	**Admissions**
Medical/Surgical (non-maternity, non-mental health)	0	0
Maternity		
Normal	0	0
C-Section	0	0
Other	0	0
Subtotal Maternity	=sum(B10:B12)	=sum(C10:C12)
Newborn	0	0
Mental Health		
Chemical Dependency	0	0
Other Mental Health	0	0
Subtotal Mental Health	=sum(B16:B17)	=sum(C16:C17)
Other	0	0
Subtotal - Part A.	**=+B8+B13+B14+B18+B19**	**=+C8+C13+C14+C18+C19**
Table 6	=table6!B29	=table6!C29
% Variance	=(B21-B23)/B21	=(C21-C23)/C21
Quarterly/Annual Financial Statement	(entered from State Page)	(entered from State Page)
% Variance	=(B21-B26)/B21	=(C21-C26)/C21
B) Specialty Facility		
Rehabilitation Care	0	0
Nursing Home (SNF/ICF)	0	0
Mental Health		
Chemical Dependency	0	0
Other Mental Health	0	0
Subtotal Mental Health	=SUM(B34:B35)	=SUM(C34:C35)
Other	0	0
Subtotal - Part B.	**=B31+B32+B36+B37**	**=C31+C32+C36+C37**
Grand Total	**=B21+B39**	**=C21+C39**

Table 4 - (Specify Category of Membership)
(Company Name)
For the reporting period ending: (insert appropriate date)

Ambulatory Utilization by Provider Type:

	Member Encounters
Physician Encounters	
Primary Care	0
Pediatric Specialists	0
OB/GYN	0
Mental Health/Psychiatry/Chemical Dependency	0
Specialties	0
Subtotal	**=SUM(B9:B13)**
Quarterly/Annual Financial Statement	(entered from State Page)
% Variance	=(B15-B17)/B15
Other Professional Provider Encounters	
Mental Health	0
Chiropractic	0
All Others	0
Subtotal	**=SUM(B21:B23)**
Quarterly/Annual Financial Statement	(entered from State Page)
% Variance	=(B25-B27)/B25
Total	**=B15+B25**
Table 7	=table 7!B29
% Variance	=(B30-B32)/B30
Quarterly/Annual Financial Statement	(entered from State Page)
% Variance	=(B30-B35)/B30
Average Cost per Mental Health Encounter	=(COS!F12+COS!F13)/(table4!B12+table4!B21)

EXHIBIT 3C

Table 5 - (Specify Category of Membership)
(Company Name)
For the reporting period ending: (insert appropriate date)

Other Services (Non-Admissions)

	Member Encounters
Home Health Care Visits	0
Surgical Center (non-hospital)	0
In/Out Surgery (Hospital/ Ambulatory-Same Day Surgery)	0
Birthing Center/Room	0
Psychiatric Daycare	0
Other (not specified above)**	0
Total	**=SUM(B8:B13)**
% OTHER	=B13/B15

VII. Bibliography

Kirschstein, M.D., Ruth L.; "Insurance Parity For Mental Health: Cost, Access, And Quality: Final Report to Congress by the National Advisory Mental Health Council"; National Institutes of Health; http://www.nimh.nih.gov/parity/paritypdf.pdf; June 2000.

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Appendix

HB 191 provisions related to mental health and substance abuse treatment coverage

376.779. 1. All group health insurance policies providing coverage on an expense-incurred basis, all group service or indemnity contracts issued by a not for profit health service corporation, all self-insured group health benefit plans, of any type or description, and all such health plans or policies that are individually underwritten or provide for such coverage for specific individuals and the members of their families as nongroup policies, which provide for hospital treatment, shall provide coverage, while confined in a hospital or in a residential or nonresidential facility certified by the department of mental health, for treatment of alcoholism on the same basis as coverage for any other illness, except that coverage may be limited to thirty days in any policy or contract benefit period. All Missouri group contracts issued or renewed, and all Missouri individual contracts issued on or after December 31, 1980, shall be subject to this section. Coverage required by this section shall be included in the policy or contract and payment provided as for other coverage in the same policy or contract notwithstanding any construction or relationship of interdependent contracts or plans affecting coverage and payment of reimbursement prerequisites under the policy or contract.

2. **[**Every insurance company and health services corporation doing business in this state shall offer in all such policies or contracts referred to in subsection 1, benefits for chemical dependency and drug addiction which cover the following:

(1) Residential treatment programs as certified by the department of mental health;

(2) Nonresidential treatment programs certified by the department of mental health. The benefits in this subsection may be limited to eighty percent of the reasonable and customary charges for such services up to a maximum benefit of two thousand dollars during each policy or contract benefit period. Said offer may be accepted or rejected by the group or individual policyholder or contract holder or at their election they may take or purchase either or both of the benefits set out in subdivision (1) or (2); provided, however, that nothing in this section shall prohibit the insurance company and health services corporation from including all or part of the coverage set forth in this section as standard coverage in their policies or contracts issued in this state.

3.**]** Insurers, corporations or groups providing coverage may approve for payment or reimbursement vendors and programs providing services or treatment required by this section. Any vendor or person offering services or treatment subject to the provisions of this section and seeking approval for payment or reimbursement shall submit to the department of mental health a detailed description of the services or treatment program to be offered. The department of mental health shall make copies of such descriptions available to insurers, corporations or groups providing coverage under the provisions of this section. Each insurer, corporation or group providing coverage shall notify the vendor or person offering service or treatment as to its acceptance or rejection for payment or reimbursement; provided, however, payment or reimbursement shall be made for any service or treatment program certified by the department of mental health. Any notice of rejection shall contain a detailed statement of the reasons for rejection and the steps and procedures necessary for acceptance. Amended descriptions of

services or treatment programs to be offered may be filed with the department of mental health. Any vendor or person rejected for approval of payment or reimbursement may modify their description and treatment program and submit copies of the amended description to the department of mental health and to the insurer, corporation or group which rejected the original description.

[4.**] 3.** The department of mental health may issue rules necessary to carry out the provisions of this section. No rule or portion of a rule promulgated under the authority of this section shall become effective unless it has been promulgated pursuant to the provisions of section 536.024, RSMo.

[5.**] 4.** All substance abuse treatment programs in Missouri receiving funding from the Missouri department of mental health must be certified by the department.

376.810. As used in sections 376.810 to 376.814, the following terms mean:

(1) "Chemical dependency", the psychological or physiological dependence upon and abuse of drugs, including alcohol, characterized by drug tolerance or withdrawal and impairment of social or occupational role functioning or both;

(2) "Community mental health center", a legal entity certified by the department of mental health or accredited by a nationally recognized organization, through which a comprehensive array of mental health services are provided to individuals;

(3) "Day program services", a structured, intensive day or evening treatment or partial hospitalization program, certified by the department of mental health or accredited by a nationally recognized organization;

(4) "Episode", a distinct course of chemical dependency treatment separated by at least thirty days without treatment;

(5) "Health insurance policy", all group health insurance policies providing coverage on an expense-incurred basis, all group service or indemnity contracts issued by a not for profit health services corporation, all self-insured group health benefit plans of any type or description to the extent that regulation of such plans is not preempted by federal law, and all such health insurance policies or contracts that are individually underwritten or provide such coverage for specific individuals and members of their families as nongroup policies, which provide for hospital treatment. For the purposes of subsection 2 of section 376.811, "health insurance policy" shall also include any group or individual contract issued by a health maintenance organization. The provisions of sections 376.810 to 376.814 shall not apply to policies which provide coverage for a specified disease only, other than for mental illness or chemical dependency;

(6) "Licensed professional", a licensed physician specializing in the treatment of mental illness, a licensed psychologist, a licensed clinical social worker or a licensed professional counselor**. Only prescription rights under this act shall apply to medical physician's and doctors of osteopathy**;

(7) "Managed care", the determination of availability of coverage under a health insurance policy through the use of clinical standards to determine the medical necessity of an admission or treatment, and the level and type of treatment, and appropriate setting for treatment, with required authorization on a prospective, concurrent or retrospective basis, sometimes involving case management;

(8) "Medical detoxification", hospital inpatient or residential medical care to ameliorate acute medical conditions associated with chemical dependency;

(9) "Nonresidential treatment program", program certified by the department of mental health involving structured, intensive treatment in a nonresidential setting;

(10) "Recognized mental illness", those conditions classified as "mental disorders" in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, but shall not include mental retardation;

(11) "Residential treatment program", program certified by the department of mental health involving residential care and structured, intensive treatment;

(12) "Social setting detoxification", a program in a supportive nonhospital setting designed to achieve detoxification, without the use of drugs or other medical intervention, to establish a plan of treatment and provide for medical referral when necessary.

376.811. 1. Every insurance company and health services corporation doing business in this state shall offer in all health insurance policies, benefits or coverage for chemical dependency meeting the following minimum standards:

(1) Coverage for outpatient treatment through a nonresidential treatment program, or through partial- or full-day program services, of not less than twenty-six days per policy benefit period;

(2) Coverage for residential treatment program of not less than twenty-one days per policy benefit period;

(3) Coverage for medical or social setting detoxification of not less than six days per policy benefit period;

(4) The coverages set forth in this subsection may be subject to a separate lifetime frequency cap of not less than ten episodes of treatment, except that such separate lifetime frequency cap shall not apply to medical detoxification in a life-threatening situation as determined by the treating physician and subsequently documented within forty-eight hours of treatment to the reasonable satisfaction of the insurance company or health services corporation; and

(5) The coverages set forth in this subsection shall be:

(a) Subject to the same coinsurance, co-payment and deductible factors as apply to physical illness;

(b) Administered pursuant to a managed care program established by the insurance company or health services corporation; and

(c) Covered services may be delivered through a system of contractual arrangements with one or more providers, hospitals, nonresidential or residential treatment programs, or other mental health service delivery entities certified by the department of mental health, or accredited by a nationally recognized organization, or licensed by the state of Missouri.

2. In addition to the coverages set forth in subsection 1 of this section, every insurance company, health services corporation and health maintenance organization doing business in this state shall offer in all health insurance policies, benefits or coverages for recognized mental illness, excluding chemical dependency, meeting the following minimum standards:

(1) Coverage for outpatient treatment, including treatment through partial- or full-day program services, for mental health services for a recognized mental illness rendered by a licensed professional to the same extent as any other illness;

(2) Coverage for residential treatment programs for the therapeutic care and treatment of a recognized mental illness when prescribed by a licensed professional and rendered in a psychiatric residential treatment center licensed by the department of mental health or accredited by the Joint Commission on Accreditation of Hospitals to the same extent as any other illness;

(3) Coverage for inpatient hospital treatment for a recognized mental illness to the same extent as for any other illness, not to exceed ninety days per year;

(4) The coverages set forth in this subsection shall be subject to the same coinsurance, co-payment, deductible, annual maximum and lifetime maximum factors as apply to physical illness; and

(5) The coverages set forth in this subsection may be administered pursuant to a managed care program established by the insurance company, health services corporation or health maintenance organization, and covered services may be delivered through a system of contractual arrangements with one or more providers, community mental health centers, hospitals, nonresidential or residential treatment programs, or other mental health service delivery entities certified by the department of mental health, or accredited by a nationally recognized organization, or licensed by the state of Missouri.

3. The offer required by sections 376.810 to 376.814 may be accepted or rejected by the group or individual policyholder or contract holder and, if accepted, shall fully and completely satisfy and substitute for the coverage under section 376.779. Nothing in sections 376.810 to 376.814 shall prohibit an insurance company, health services corporation or health maintenance organization from including all or part of the coverages set forth in sections 376.810 to 376.814 as standard coverage in their policies or contracts issued in this state.

4. Every insurance company, health services corporation and health maintenance organization doing business in this state shall offer in all health insurance policies mental health benefits or

coverage as part of the policy or as a supplement to the policy. Such mental health benefits or coverage shall include at least two sessions per year to a licensed psychiatrist, licensed psychologist, licensed professional counselor, or licensed clinical social worker acting within the scope of such license and under the following minimum standards:

(1) Coverage and benefits in this subsection shall be for the purpose of diagnosis or assessment, but not dependent upon findings; and

(2) Coverage and benefits in this subsection shall not be subject to any conditions of preapproval, and shall be deemed reimbursable as long as the provisions of this subsection are satisfied; and

(3) Coverage and benefits in this subsection shall be subject to the same coinsurance, co-payment and deductible factors as apply to regular office visits under coverages and benefits for physical illness.

5. If the group or individual policyholder or contractholder rejects the offer required by this section, then the coverage shall be governed by the mental health and chemical dependency insurance act as provided in sections 376.825 to 376.835.

376.825. Sections 376.825 to 376.835 shall be known and may be cited as the "Mental Health and Chemical Dependency Insurance Act".

376.826. For the purposes of sections 376.825 to 376.835 the following terms shall mean:

(1) "Director", the director of the department of insurance;

(2) "Health insurance policy" or "policy", all group health insurance policies providing coverage on an expense-incurred basis, all group service or indemnity contracts issued by a not for profit health services corporation, all self-insured group health benefit plans of any type or description to the extent that regulation of such plans is not preempted by federal law, and all such health insurance policies or contracts that are individually underwritten or provide such coverage for specific individuals and members of their families as nongroup policies, which provide for hospital treatments. The term shall also include any group or individual contract issued by a health maintenance organization. The provisions of sections 376.825 to 376.835 shall not apply to policies which provide coverage for a specified disease only, other than for mental illness or chemical dependency;

(3) "Insurer", an entity licensed by the department of insurance to offer a health insurance policy;

(4) "Mental illness", the following disorders contained in the International Classification of Diseases (ICD-9-CM):

(a) Schizophrenic disorders and paranoid states (295 and 297, except 297.3);

(b) Major depression, bipolar disorder, and other affective psychoses (296);

(c) Obsessive compulsive disorder, post-traumatic stress disorder and other major anxiety disorders (300.0, 300.21, 300.22, 300.23, 300.3 and 309.81);

(d) Early childhood psychoses, and other disorders first diagnosed in childhood or adolescence (299.8, 312.8, 313.81 and 314);

(e) Alcohol and drug abuse (291, 292, 303, 304, and 305, except 305.1); and

(f) Anorexia nervosa, bulimia and other severe eating disorders (307.1, 307.51, 307.52 and 307.53);

(g) Senile organic psychotic conditions (290);

(5) "Rate", "term", or "condition", any lifetime limits, annual payment limits, episodic limits, inpatient or outpatient service limits, and out-of-pocket limits. This definition does not include deductibles, copayments, or coinsurance prior to reaching any maximum out-of-pocket limit. Any out-of-pocket limit under a policy shall be comprehensive for coverage of mental illness and physical conditions.

376.827. 1. Nothing in this bill shall be construed as requiring the coverage of mental illness.

2. Except for the coverage required pursuant to subsection 1 of section 376.779, and the offer of coverage required pursuant to sections 376.810 through 376.814, if any of the mental illness disorders enumerated in subdivision (4) of section 376.826 are provided by the health insurance policy, the coverage provided shall include all the disorders enumerated in subdivision (4) of section 376.826 and shall not establish any rate, term, or condition that places a greater financial burden on an insured for access to evaluation and treatment for mental illness than for access to evaluation and treatment for physical conditions, generally, except that alcohol and other drug abuse services shall have a minimum of thirty days total inpatient treatment and a minimum of twenty total visits for outpatient treatment for each year of coverage. A lifetime limit equal to four times such annual limits may be imposed. The days allowed for inpatient treatment can be converted for use for outpatient treatment on a two-for-one basis.

3. Deductibles, copayment or coinsurance amounts for access to evaluation and treatment for mental illness shall not be unreasonable in relation to the cost of services provided.

4. A health insurance policy that is a federally qualified plan of benefits shall be construed to be in compliance with sections 376.825 to 376.833 if the policy is issued by a federally qualified health maintenance organization and the federally qualified health maintenance organization offered mental health coverage as required by sections 376.825 to 376.833. If such coverage is rejected, the federally qualified health maintenance organization shall, at a minimum, provide coverage for mental health services as a basic health service as required by the Federal Public Health Service Act, 42 U.S.C. Section 300e., et seq.

5. Health insurance policies that provide mental illness benefits pursuant to sections 376.825 to 376.835 shall be deemed to be in compliance with the requirements of subsection 1 of section 376.779.

6. The director may disapprove any policy that the director determines to be inconsistent with the purposes of this section.

376.828. 1. The coverages set forth in sections 376.825 to 376.835 may be administered pursuant to a managed care program established by the insurance company, health services corporation or health maintenance organization, and covered services may be delivered through a system of contractual arrangements with one or more licensed providers, community mental health centers, hospitals, nonresidential or residential treatment programs, or other mental health service delivery entities certified by the department of mental health, or accredited by a nationally recognized organization, or licensed by the state of Missouri. Nothing in this section shall authorize any unlicensed provider to provide covered services.

2. An insurer may use a case management program for mental illness benefits to evaluate and determine medically necessary and clinically appropriate care and treatment for each patient.

3. Nothing in sections 376.825 to 376.835 shall be construed to require a managed care plan as defined by section 354.600, RSMo, when providing coverage for benefits governed by sections 376.825 to 376.835, to cover services rendered by a provider other than a participating provider, except for the coverage pursuant to subsection 4 of section 376.811, RSMo. An insurer may contract for benefits provided in sections 376.825 to 376.835 with a managing entity or group of providers for the management and delivery of services for benefits governed by sections 376.825 to 376.835.

376.829. 1. The provisions of section 376.827 shall not be violated if the insurer decides to apply different limits or exclude entirely from coverage the following:

(1) Marital, family, educational, or training services unless medically necessary and clinically appropriate;

(2) Services rendered or billed by a school or halfway house;

(3) Care that is custodial in nature;

(4) Services and supplies that are not medically necessary nor clinically appropriate; or

(5) Treatments that are considered experimental.

2. The director shall grant a policyholder a waiver from the provisions of section 376.827 if the policyholder demonstrates to the director by actual experience over any consecutive twenty-four-month period that compliance with sections 376.825 to 376.835 has increased

the cost of the health insurance policy by an amount that results in a two percent increase in premium costs to the policyholder.

376.833. 1. The provisions of sections 376.825 to 376.835 apply to applications for coverage made on or after January 1, 2000, and to health insurance policies issued or renewed on or after such date to residents of this state. Multi-year group policies need not comply until the expiration of their current multi-year term unless the policyholder elects to comply before that time.

2. The director shall perform a study to assess the impact of HB 191 on insurers, business interests, providers, and consumers of mental health and substance abuse treatment services. The director shall report the findings of this study to the general assembly by January 1, 2004.

376.835. Notwithstanding the provision of subsection 1 of section 376.827, all health insurance policies which cover state employees including the Missouri consolidated health care plan shall include coverage for mental illness. Multi-year group policies need not comply until the expiration of their current multi-year term unless the policyholder elects to comply before that time.